Independent Resolutions Inc.

An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Family Medicine

Description of the service or services in dispute:

10 visits of chronic pain management for the low back

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☑ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

The patient is a xx year old whose date of injury is xx/xx/xx. Designated doctor evaluation dated xxxx indicates that the patient entered the room in a wheelchair and stated that he had an injury to his back while lifting something. The patient has no sensation below the waist. He has no motor below the waist. MRI of the lumbar spine dated xxxx revealed lateral recesses at L4-5 are borderline stenotic secondary spondylosis and disc bulging but no significant central canal stenosis is identified. No significant canal narrowing at L1-2, L2-3, L3-4 or L5-S1 are seen. Evaluation dated xxxxx indicates that he has completed physical therapy and aquatic therapy. He states that he has learned a lot thus far from his participation in a chronic pain management program and would like to continue. BDI decreased from 20 to 9 and BAI increased from 8 to 9. Preauthorization request dated xxxxx indicates that the patient's symptoms became progressively worse and he was unable to walk or bear weight on his lower extremities. The patient has to use a wheelchair for ambulation. The patient has completed 10 sessions of a chronic pain management program. The patient reportedly has increased muscle strength, increased nerve sensation, increased flexibility, decreased pain medication use and a positive disposition. Functional capacity evaluation dated xxxx indicates that current PDL is below sedentary below the waist and light above the waist. The patient's functional capacity has changed very little since last tested on xxxxx. Evaluation dated xxxxx indicates that the patient showed improvement by a decrease in his frequency of exhibiting pain. GAF increased from 50 to 58.

Initial request for 10 visits of chronic pain management was non-certified on xxxx noting that the outcomes (goals) for the necessity of continued treatment are not clearly identified. There is little to no evidence of significant subjective and objective gains. Letter of medical necessity dated xxxx indicates that the patient did not undergo the functional capacity evaluation until a month after the initial 10 sessions of chronic pain management program. The denial was upheld on appeal dated xxxxx noting that the patient currently does not have demonstrable psychological barriers. 10 prior sessions of chronic pain management program did not result in significant physical performance improvement.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

The patient sustained injuries over x years ago and is currently confined to a wheelchair. The patient has completed 10 visits of chronic pain management program to date. The Official Disability Guidelines note that

treatment is not suggested for longer than 2 weeks without evidence of compliance and significant demonstrated efficacy as documented by subjective and objective gains. The submitted functional capacity evaluation dated xxxx states that the patient's functional capacity has changed very little since last tested on xxxxx. Current PDL is below sedentary below the waist and light above the waist. The patient's Beck scales are in the mild range. The specific goals of treatment remain unclear. Therefore, medical necessity is not established in accordance with the Official Disability Guidelines. As such, it is the opinion of the reviewer that the request for 10 visits of chronic pain management for the low back is not recommended as medically necessary.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☑ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☑ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice Parameters
- ☐ Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical **Literature** (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)